

Prostate cancer

Quality standard

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This standard is based on CSG2 and NG131.

This standard should be read in conjunction with QS13, QS15, QS45, QS106 and QS124.

Introduction

This quality standard covers the care of people referred to secondary care with suspected or diagnosed prostate cancer, and people having follow-up for prostate cancer in primary care.

The recognition and referral of people with suspected cancer in primary care is covered by the quality standard on [suspected cancer](#).

For more information see the prostate cancer [topic overview](#).

Why this quality standard is needed

Prostate cancer is the most common cancer in men and makes up 26% of all male cancer diagnoses in the UK. According to Cancer Research UK's [prostate cancer statistics](#) there were 10,837 deaths from prostate cancer in the UK in 2012.

Prostate cancer is predominantly a disease of older men (aged 65–79 years) but around 25% of cases occur in men younger than 65.

Family history has been shown to be a risk factor. The relative risk rises as the number of first-degree relatives diagnosed with prostate cancer increases.

Ethnicity has also been shown to be a risk factor for prostate cancer, with higher rates seen in people of black African or Caribbean family origin and the lowest in people of Asian family origin.

Cases of prostate cancer are expected to increase, even if the incidence rate stays constant, because of the ageing population. The financial burden of treatment, including the need for treatment facilities and trained specialists, will grow as more people are diagnosed with the disease.

People with prostate cancer have more emergency than elective hospital admissions during their last year of life ([National End of Life Care Intelligence Network 2012](#)). In those dying from prostate cancer, the average cost of hospital admissions is nearly half (47%) of the average cost of care

during the last year of life (National End of Life Care Intelligence Network 2012). The estimated total cost of inpatient care per person during their last year of life is reported to be £6,931 for prostate cancer.

The quality standard is expected to contribute to improvements in the following outcomes:

- quality of life
- the need for care and support
- premature deaths from prostate cancer
- patient experience of hospital care.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- [Adult Social Care Outcomes Framework 2015–16](#)
- [NHS Outcomes Framework 2015–16](#)
- [Public Health Outcomes Framework 2013–16.](#)

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [Adult Social Care Outcomes Framework 2015–16](#)

Domain	Overarching and outcome measures
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<p>1 Enhancing quality of life for people with care and support needs</p>	<p>Overarching measure</p> <p>1A Social care-related quality of life*</p> <p>Outcome measures</p> <p>People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to meet their needs</p> <p>1B Proportion of people who use services who have control over their daily lives</p> <p>1C Proportion of people using social care who receive self-directed support, and those receiving direct payments</p> <p>Carers can balance their caring roles and maintain their desired quality of life</p> <p>1D Carer-reported quality of life*</p>
<p>2 Delaying and reducing the need for care and support</p>	<p>Outcome measures</p> <p>Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services</p> <p>2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services**</p>

<p>3 Ensuring that people have a positive experience of care and support</p>	<p>Overarching measure</p> <p>People who use social care and their carers are satisfied with their experience of care and support services</p> <p>3A Overall satisfaction of people who use services with their care and support</p> <p>3B Overall satisfaction with social services of carers</p> <p>Placeholder 3E Effectiveness of integrated care</p> <p>Outcome measures</p> <p>Carers feel that they are respected as equal partners throughout the care process</p> <p>3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for</p> <p>People know what choices are available to them locally, what they are entitled to, and who to contact when they need help</p> <p>3D The proportion of people who use services and carers who find it easy to find information about support</p> <p>People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual</p> <p><i>This information can be taken from the Adult Social Care Survey and used for analysis at the local level</i></p>
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4 Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm	<p>Overarching measure</p> <p>4A The proportion of people who use services who feel safe*</p> <p>Outcome measures</p> <p>Everyone enjoys physical safety and feels secure</p> <p>People are free from physical and emotional abuse, harassment, neglect and self-harm</p> <p>People are protected as far as possible from avoidable harm, disease and injuries</p> <p>People are supported to plan ahead and have the freedom to manage risks the way that they wish</p> <p>4B The proportion of people who use services who say that those services have made them feel safe and secure</p> <p><i>Placeholder 4C Proportion of completed safeguarding referrals where people report they feel safe</i></p>
Aligning across the health and care system	
* Indicator complementary	
** Indicator shared	

Table 2 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p>Overarching indicators</p> <p>1B Life expectancy at 75</p> <p>i Males</p> <p>Improvement areas</p> <p>Reducing premature mortality from the major causes of death</p> <p>1.4 Under 75 mortality rate from cancer*</p>

<p>2 Enhancing quality of life for people with long-term conditions</p>	<p>Overarching indicators</p> <p>2 Health-related quality of life for people with long-term conditions**</p> <p>Improvement areas</p> <p>Ensuring people feel supported to manage their condition</p> <p>2.1 Proportion of people feeling supported to manage their condition</p> <p>Improving functional ability in people with long-term conditions</p> <p>2.2 Employment of people with long-term conditions***,</p> <p>Enhancing quality of life for carers</p> <p>2.4 Health-related quality of life for carers**</p>
<p>3 Helping people to recover from episodes of ill health or following injury</p>	<p>Overarching indicators</p> <p>3a Emergency admissions for acute conditions that should not usually require hospital admission</p>

4 Ensuring that people have a positive experience of care	<p><i>Overarching indicators</i></p> <p>4a Patient experience of primary care</p> <p>i GP services</p> <p>ii GP out-of-hours services</p> <p>4b Patient experience of hospital care</p> <p><i>4c Friends and family test</i></p> <p><i>Improvement areas</i></p> <p>Improving people's experience of outpatient care</p> <p>4.1 Patient experience of outpatient services</p> <p>Improving hospitals' responsiveness to personal needs</p> <p>4.2 Responsiveness to in-patients' personal needs</p> <p>Improving access to primary care services</p> <p>4.4 Access to i GP services</p> <p>Improving the experience of care for people at the end of their lives</p> <p>4.6 Bereaved carers' views on the quality of care in the last 3 months of life</p> <p>Improving people's experience of integrated care</p> <p><i>4.9 People's experience of integrated care**</i></p>
<p>Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or NHS Outcomes Framework (NHSOF)</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p> <p><i>Indicators in italics are in development</i></p>	

Table 3 Public health outcomes framework for England, 2013–16

Domain	Objectives and indicators
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4 Healthcare public health and preventing premature mortality	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p>Indicators</p> <p>4.5 Mortality from cancer</p>
<p>Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or Public Health Outcomes Framework (PHOF)</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p> <p><i>Indicators in italics are in development</i></p>	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to prostate cancer.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE Pathway on [patient experience in adult NHS services](#)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for prostate cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole prostate cancer care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with prostate cancer.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should

consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality prostate cancer service are listed in [related quality standards](#).

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating people with prostate cancer should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people with prostate cancer. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1 People with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

Statement 2 People with low-risk localised prostate cancer for whom radical treatment is suitable are offered a choice between active surveillance, radical prostatectomy or radical radiotherapy.

Statement 3 People with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.

Statement 4 People with adverse effects of prostate cancer treatment are referred to specialist services.

Statement 5 People with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer multidisciplinary team.

Quality statement 1: Discussion with a named nurse specialist

Quality statement

People with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

Rationale

Nurse specialists are key points of contact for people with prostate cancer. They provide information about treatment options, answer questions or concerns and support people to make decisions about their care. This is particularly important immediately after diagnosis and when difficult choices about treatment need to be made. Nurse specialists also provide personalised care plans and information about support services.

Quality measures

Structure

Evidence of local arrangements to ensure that people with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

Data source: Local data collection, [National Prostate Cancer Audit](#) and [National Cancer Patient Experience Survey 2014](#).

Process

Proportion of people with prostate cancer who have a recorded discussion about treatment options and adverse effects with a named nurse specialist.

Numerator – the number in the denominator who have a recorded discussion about treatment options and adverse effects with a named nurse specialist.

Denominator – the number of people with prostate cancer.

Data source: Local data collection, [National Prostate Cancer Audit](#) and [National Cancer Patient Experience Survey 2014](#).

Outcome

Rates of people with prostate cancer satisfied with the discussion about treatment options and adverse effects.

Data source: Local data collection and [National Cancer Patient Experience Survey 2014](#).

What the quality statement means for different audiences

Service providers (such as hospitals, specialist prostate cancer multidisciplinary teams and specialist prostate cancer services) ensure that people with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

Healthcare professionals ensure that people with prostate cancer have a discussion about treatment options and adverse effects with a named nurse specialist.

Commissioners (such as clinical commissioning groups and NHS England area teams) ensure that the services they commission have sufficient nurse specialists available to offer a discussion about treatment options and adverse effects to people with prostate cancer.

People with prostate cancer have a discussion about treatment options and adverse effects with a named nurse with experience in prostate cancer. They feel informed about their treatment options and side effects, and supported to make decisions about their treatment.

Source guidance

- [Prostate cancer: diagnosis and management](#) (2019) NICE guideline NG131, recommendations 1.1.1, 1.1.9 and 1.1.12
- [Improving outcomes in urological cancers](#) (2002) NICE guideline CSG2

Definitions of terms used in this quality statement

Adverse effects

Adverse effects of prostate cancer treatment may include:

- sexual dysfunction
- loss of libido

- impotence
- urinary incontinence
- radiation-induced enteropathy
- hot flushes
- osteoporosis
- cardiovascular complications
- gynaecomastia
- fatigue
- weight gain
- metabolic syndrome.

[Adapted from NICE's guideline on [prostate cancer](#)]

Nurse specialist

A nurse with a urology or oncology background who is a specialist in the management of prostate cancer.

[Expert opinion]

Support services

Supportive care includes a number of services, both generalist and specialist, that may be required to support people with cancer and their carers.

[Adapted from NICE's guideline on [improving supportive and palliative care for adults with cancer](#)]

Equality and diversity considerations

People of black African or Caribbean family origin are more likely to develop prostate cancer than other people. Despite this, awareness of prostate cancer is low among people in these groups and the nurse specialist should be aware of this when discussing prostate cancer with them.

Similarly, older people are at higher risk of developing prostate cancer than younger people, but may be less likely to continue to engage with health services after the initial contact. The nurse specialist should be aware of this when discussing prostate cancer with older people.

People who are gay, bisexual or transgender have a risk of developing prostate cancer. Healthcare professionals should be aware of their psychosexual needs, lifestyle and the impact of different treatment options.

Quality statement 2: Treatment options

Quality statement

People with low-risk localised prostate cancer for whom radical treatment is suitable are offered a choice between active surveillance, radical prostatectomy or radical radiotherapy.

Rationale

People who are diagnosed with low-risk localised prostate cancer can be offered different treatment options, including radical prostatectomy, radical radiotherapy and active surveillance. It is important that people for whom it is suitable know that active surveillance is also an option for low-risk localised prostate cancer. This can reduce overtreatment and increase capacity for rapid treatment of high-risk disease. It can also reduce the number of people unnecessarily having radical treatment and therefore experiencing adverse effects, and decrease the cost of treating and managing these adverse effects. By discussing all the treatment options available to them, people can make an informed decision on their preferred option.

Quality measures

Structure

Evidence of local arrangements to ensure that people with low-risk localised prostate cancer for whom radical treatment is suitable are offered a choice between active surveillance, radical prostatectomy or radical radiotherapy.

Data source: Local data collection.

Process

Proportion of people with low-risk localised prostate cancer for whom radical treatment is suitable who are offered a choice between active surveillance, radical prostatectomy or radical radiotherapy.

Numerator – the number in the denominator who are offered a choice between active surveillance, radical prostatectomy or radical radiotherapy.

Denominator – the number of people with low-risk localised prostate cancer for whom radical treatment is suitable.

Data source: Local data collection.

Outcome

a) Rates of people with low-risk localised prostate cancer on active surveillance.

Data source: Local data collection.

b) Rates of people with low-risk localised prostate cancer satisfied with their chosen treatment option.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as hospitals, specialist urological cancer multidisciplinary teams and specialist prostate cancer services) ensure that systems are in place to offer a choice between active surveillance, radical prostatectomy or radical radiotherapy to people with low-risk localised prostate cancer for whom radical treatment is suitable.

Healthcare professionals ensure that they offer a choice between active surveillance, radical prostatectomy or radical radiotherapy to people with low-risk localised prostate cancer for whom radical treatment is suitable.

Commissioners (such as clinical commissioning groups and NHS England area teams) should monitor the treatment options offered to people with low-risk localised prostate cancer.

People whose cancer has not spread outside the prostate and whose future risk from the cancer is low are offered a choice between having regular tests but no treatment (known as active surveillance), surgery to remove the prostate (radical prostatectomy) or radiation treatment to destroy cancer cells (radiotherapy).

Source guidance

Prostate cancer: diagnosis and management (2019) NICE guideline NG131, recommendations 1.3.7, 1.3.8 and 1.3.9

Definitions of terms used in this quality statement

Active surveillance

Part of a curative strategy for people with localised prostate cancer for whom radical treatments are suitable. It keeps these people within a 'window of curability' whereby only those whose tumours are showing signs of progressing or those with a preference for intervention are considered for radical treatment. Active surveillance may therefore avoid or delay the need for radiation or surgery.

Active surveillance follows the protocol outlined in table 4 in NICE's guideline on [prostate cancer](#).

[NICE's guideline on [prostate cancer, 2014 full guideline](#)]

Low-risk localised prostate cancer

Prostate-specific antigen (PSA) less than 10 ng/ml, Gleason score 6 or below and clinical stage T1-T2A (confined to the prostate gland).

[Adapted from NICE's guideline on [prostate cancer](#)]

Radical prostatectomy

Removal of the entire prostate gland and lymph nodes by open surgery or a keyhole technique (laparoscopic or robotically assisted laparoscopic prostatectomy).

[NICE's guideline on [prostate cancer, 2014 full guideline](#)]

Radical radiotherapy

Radiation, usually X-rays or gamma rays, used to destroy tumour cells, by external beam radiotherapy or brachytherapy.

[NICE's guideline on [prostate cancer, 2014 full guideline](#)]

Equality and diversity considerations

People of black African or Caribbean family origin are more likely to develop prostate cancer than others. Despite this, awareness of prostate cancer is low among people in these groups. Similarly,

older people are at higher risk of developing prostate cancer than younger people, but may be less likely to continue to engage with health services even after the initial contact with the service. For people in these groups for whom active surveillance is suitable, healthcare professionals should highlight its importance as a treatment option.

People who are gay, bisexual or transgender have a risk of developing prostate cancer. Healthcare professionals should be aware of their psychosexual needs, lifestyle and the impact of different treatment options.

Quality statement 3: Combination therapy

Quality statement

People with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.

Rationale

Androgen deprivation therapy and radiotherapy are 2 of the treatment options available for people with intermediate- or high-risk localised prostate cancer. Combining androgen deprivation therapy with radical radiotherapy can increase the effectiveness of treatment and the chances of survival compared with either androgen deprivation therapy or radical radiotherapy alone.

Quality measures

Structure

Evidence of local arrangements to ensure that people with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination.

Data source: Local data collection.

Process

Proportion of people with intermediate- or high-risk localised prostate cancer receiving non-surgical radical treatment, who receive radical radiotherapy and androgen deprivation therapy in combination.

Numerator – the number in the denominator who received radical radiotherapy and androgen deprivation therapy in combination.

Denominator – the number of people with intermediate- or high-risk localised prostate cancer receiving non-surgical radical treatment.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as hospitals, specialised urological cancer multidisciplinary teams and specialised prostate cancer services) ensure that healthcare professionals know that radical radiotherapy and androgen deprivation therapy should be used only in combination for people with intermediate- or high-risk localised prostate cancer.

Healthcare professionals ensure that people with intermediate- or high-risk localised prostate cancer who are offered non-surgical radical treatment receive radical radiotherapy and androgen deprivation therapy in combination.

Commissioners (such as clinical commissioning groups and NHS England area teams) monitor whether people with intermediate- or high-risk localised prostate cancer offered non-surgical radical treatment are offered radical radiotherapy and androgen deprivation therapy in combination. Commissioners may wish to ask providers for evidence of practice.

People whose cancer has not spread outside the prostate and whose future risk from the cancer is medium or high are offered treatment of combined radiation treatment to destroy the cancer cells (called radiotherapy) and a drug that blocks the production of androgen, a hormone that helps cancer cells to grow, (called androgen deprivation therapy). Having radiotherapy together with androgen deprivation therapy usually works better than having just one of these treatments on its own.

Source guidance

Prostate cancer: diagnosis and management (2019) NICE guideline NG131, recommendation 1.3.19

Definitions of terms used in this quality statement

Androgen deprivation therapy

Treatment with a luteinising hormone-releasing hormone agonist such as goserelin to lower testosterone levels.

[Adapted from NICE's guideline on prostate cancer, 2014 full guideline]

High-risk localised prostate cancer

Prostate-specific antigen (PSA) greater than 20 ng/ml, Gleason score 8–10 or clinical stage T2C or greater.

[NICE's guideline on [prostate cancer](#)]

Intermediate-risk localised prostate cancer

PSA 10–20 ng/ml, Gleason score 7 or clinical stage T2B.

[NICE's guideline on [prostate cancer](#)]

Radical radiotherapy

Radiation, usually X-rays or gamma rays, used to destroy tumour cells by external beam radiotherapy or brachytherapy.

[NICE's guideline on [prostate cancer, 2014 full guideline](#)]

Equality and diversity considerations

Some older people may have previously been offered androgen deprivation therapy alone. Focusing on the benefits of combination therapy for older people with intermediate- or high-risk localised prostate cancer should help to reduce such inequalities.

People who are gay, bisexual or transgender have a risk of developing prostate cancer. Healthcare professionals should be aware of their psychosexual needs, lifestyle and the impact of different treatment options.

Quality statement 4: Managing adverse effects of treatment

Quality statement

People with adverse effects of prostate cancer treatment are referred to specialist services.

Rationale

Treatments for prostate cancer have various adverse effects that can continue after the treatment is completed. Adverse effects include sexual dysfunction, loss of libido, impotence, urinary incontinence, radiation-induced enteropathy, hot flushes, osteoporosis, cardiovascular complications, gynaecomastia and fatigue. These adverse effects can also have an emotional and psychological impact on people. Specialist services that provide interventions such as counselling, drug therapy, radiotherapy, physiotherapy and aerobic exercise can help to manage adverse effects of treatment and substantially improve the person's quality of life.

Quality measures

Structure

Evidence of local arrangements to ensure that people with adverse effects of prostate cancer treatment are referred to specialist services.

Data source: Local data collection and the [National Prostate Cancer Audit](#).

Process

Proportion of people with adverse effects of prostate cancer treatment who use specialist services.

Numerator – the number in the denominator who use specialist services.

Denominator – the number of people with adverse effects of prostate cancer treatment.

Data source: Local data collection and the [National Prostate Cancer Audit](#).

What the quality statement means for different audiences

Service providers (such as hospitals, specialist urological cancer multidisciplinary teams and specialist prostate cancer services) ensure that systems are in place for people with adverse effects

of prostate cancer treatment to be referred to specialist services.

Healthcare professionals refer people with adverse effects of prostate cancer treatment to specialist services.

Commissioners (such as clinical commissioning groups and NHS England area teams) have pathways in place to ensure that people with adverse effects of prostate cancer treatment are referred to specialist services.

People who have side effects from prostate cancer treatment are referred to specialist services (such as erectile dysfunction or continence services) to help stop or ease the side effects.

Source guidance

Prostate cancer: diagnosis and management (2019) NICE guideline NG131, recommendations 1.3.33, 1.3.36, 1.3.39, 1.4.3, 1.4.8, 1.4.13, 1.4.14, 1.4.16, 1.4.18 and 1.4.19

Definitions of terms used in this quality statement

Adverse effects

Adverse effects include:

- sexual dysfunction
- loss of libido
- impotence
- urinary incontinence
- radiation-induced enteropathy
- hot flushes
- osteoporosis
- cardiovascular complications
- gynaecomastia

- fatigue
- weight gain
- metabolic syndrome.

[Adapted from NICE's guideline on [prostate cancer](#)]

Specialist services

The specialist services include erectile dysfunction services, continence services and psychosexual counselling.

[Adapted from NICE's guideline on [prostate cancer](#)]

Equality and diversity considerations

Older people may need encouragement to engage with specialist services as they tend not to use the health service as much as other people.

People who are gay, bisexual or transgender have a risk of developing prostate cancer. Healthcare professionals should be aware of their psychosexual needs, lifestyle and the impact of different treatment options.

Quality statement 5: Hormone-relapsed metastatic prostate cancer

Quality statement

People with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer multidisciplinary team (MDT).

Rationale

Discussion by the urological cancer MDT is a means of ensuring that an opinion from an oncologist and/or palliative care specialist is obtained. Having a variety of opinions from experts who are aware of all current treatment options means that there is a better chance to identify the best options for the person. Those options can then be discussed with the person.

Quality measures

Structure

Evidence of local arrangements to ensure that people with hormone-relapsed metastatic disease have their treatment options discussed by the urological cancer MDT.

Data source: Local data collection and the [National Prostate Cancer Audit](#).

Process

Proportion of people with hormone-relapsed metastatic disease who have their treatment options discussed by the urological cancer MDT.

Numerator – the number in the denominator who have their treatment options discussed by the urological cancer MDT.

Denominator – the number of people with hormone-relapsed metastatic prostate cancer.

Data source: Local data collection and the [National Prostate Cancer Audit](#).

What the quality statement means for different audiences

Service providers (such as hospitals, specialist urological cancer MDTs and specialist prostate cancer services) ensure that systems are in place for people with hormone-relapsed metastatic

prostate cancer to have their treatment options discussed by the urological cancer MDT.

Healthcare professionals ensure that people with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer MDT.

Commissioners (such as clinical commissioning groups and NHS England area teams) monitor whether providers have systems in place to ensure that people with hormone-relapsed metastatic prostate cancer have their treatment options discussed by the urological cancer MDT.

People with cancer that has spread outside the prostate and whose drug treatment (to block the production of hormones that help cancer cells to grow) has stopped working have their treatment options discussed by a specialist team of healthcare professionals with different kinds of expertise in prostate cancer. This is to make sure that all the different treatment options are discussed and all suitable treatments are offered.

Source guidance

Prostate cancer: diagnosis and management (2019) NICE guideline NG131, recommendation 1.5.11

Definitions of terms used in this quality statement

Hormone-relapsed prostate cancer

Prostate cancer after failure of primary androgen deprivation therapy.

[NICE's guideline on prostate cancer, 2014 full guideline]

Urological cancer MDT

A team that includes specialists in urology, oncology, pathology, radiology, palliative care, diet and nursing.

[Adapted from NICE's guideline on prostate cancer, 2014 full guideline and the British Uro-Oncology Group and British Association of Urological Surgeons MDT (multi-disciplinary team) guidance for managing prostate cancer]

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

See NICE's [how to use quality standards](#) for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#) and NICE's cancer service guidance on [improving outcomes in urological cancers](#) and the National Cancer Peer Review Programme's Manual for cancer services: urology cancer.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between healthcare professionals and people with suspected or diagnosed prostate cancer is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with suspected or diagnosed prostate cancer should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards [process guide](#).

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Prostate cancer: diagnosis and management](#) (2019) NICE guideline NG131

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Healthcare Quality Improvement Partnership (2014) [National Prostate Cancer Audit](#)
- Department of Health (2013) [Improving outcomes: a strategy for cancer – impact assessment](#)
- Department of Health (2013) [Improving outcomes: a strategy for cancer – third annual report](#)
- Department of Health (2012) [National cancer patients' experience survey programme 2012/13](#)
- Department of Health (2011) [Cancer: systematic delivery of interventions to reduce cancer mortality and increase cancer survival at population level](#)
- Department of Health (2011) [Commissioning cancer services](#)

Definitions and data sources for the quality measures

- Healthcare Quality Improvement Partnership (2014) [National Prostate Cancer Audit](#)
- [Prostate cancer: diagnosis and management](#) (2019) NICE guideline NG131

Related NICE quality standards

- [Suspected cancer](#) (2016 updated 2017) NICE quality standard 124
- [Bladder cancer](#) (2015) NICE quality standard 106
- [Lower urinary tract symptoms in men](#) (2013) NICE quality standard 45
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15
- [End of life care for adults](#) (2011 updated 2017) NICE quality standard 13

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 4. Membership of this committee is as follows:

Miss Alison Allam

Lay member

Dr Harry Allen

Consultant old age psychiatrist, Manchester Mental Health and Social Care Trust

Dr Jo Bibby

Director of strategy, The Health Foundation

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Lead nurse specialist in neurology, Norfolk Community Health and Care

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Quality improvement programme lead, Strategic Clinical Networks, NHS England

Mr Alaster Rutherford

Primary care pharmacist, NHS Bath and North East Somerset

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Mr John Walker

Head of operations, Greater Manchester West Mental Health NHS Foundation Trust

The following specialist members joined the committee to develop this quality standard:

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Lay member, Prostate Cancer UK, London

Dr John Graham

Consultant in clinical oncology, Taunton & Somerset NHS Foundation Trust

Professor Peter Hoskin

Consultant clinical oncologist, Mount Vernon Cancer Centre and University College London

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Nurse consultant urology oncology, University Hospital Ayr

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NICE project team

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Karyo Angeloudis

Lead technical analyst

Jenny Mills

Project manager

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Coordinator

Update information

May 2019: Changes have been made to align this quality standard with the NICE guideline on [prostate cancer](#). Statement 2 has been amended so that active surveillance is now an equal choice alongside prostatectomy and radiotherapy for people with low-risk localised prostate cancer, in line with the updated guideline. Terminology has been changed from 'men' to 'people' throughout to ensure that people who do not identify as men but who have a prostate are included in the guideline. References and links to source guidance have also been updated.

Minor changes since publication

December 2016: Data source updated for statement 1.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards [process guide](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Primary Care Urology Society](#)
- [Royal College of General Practitioners](#)
- [Royal College of Pathologists](#)
- [Society and College of Radiographers](#)
- [National Osteoporosis Society](#)